STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001143	A. BUILDING: _____ B. WING _____	C 02/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTAGE MANOR HEALTH CARE FACILITY	3016 PORTAGE AVE SOUTH BEND, IN 46628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00190942. Complaint IN00190942- Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 22, 2016 Facility number: 001143 Provider number: 001143 AIM number: N/A Residential census: 123 Sample: 3 Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00190942. QR was completed by 99993 on 02/23/16.	R 000		